

**STATE OF COLORADO**  
**2005 Colorado Health Plan Description Form -- Health Maintenance Organizations (HMOs)**

**San Luis Valley HMO**

**PART A: TYPE OF COVERAGE**

1. TYPE OF PLAN	Health Maintenance Organization (HMO)
2. OUT-OF-NETWORK CARE COVERED? <sup>1</sup>	Only for emergency and urgent care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available only in the following counties: Alamosa, Conejos, Costilla, Mineral, Rio Grande, and Saguache

**PART B: SUMMARY OF BENEFITS**

This form is not a contract. It is only a summary. The contents of this form are subject to provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

4. ANNUAL DEDUCTIBLE – Individual & family	No Deductibles
5. OUT-OF-POCKET ANNUAL MAXIMUM <sup>2</sup> a) Individual b) Family	2 X annual premium
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No Lifetime maximum (See Transplants, Line #24)
7A. COVERED PROVIDERS	All physicians in the San Luis Valley six-county service area; approximately 1,000 specialty providers in Colorado; 15 Colo. hospitals. See provider directory for complete list.
7B. With respect to network plans, are all of the providers listed in 7A accessible to me through my primary care physician?	Yes
8. ROUTINE MEDICAL OFFICE VISITS	\$30 per visit copay-PCP \$50 per visit copay-Specialist
9. PREVENTIVE CARE a) Children services b) Adult services	\$30 per visit copay-PCP; \$50 per visit copay-Specialist \$30 per visit copay-PCP; \$50 per visit copay-Specialist
10. MATERNITY a. Prenatal care b. Delivery & inpatient well baby care	a. \$30 per visit copay-PCP; \$50 per visit copay-Specialist b. \$250 copay per day; up to maximum of \$1,000 copay per admission
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescription	\$15 copay for formulary generic; \$40 copay for formulary brand name ; \$60 copay for non-formulary brand name and non-formulary generic. Prescriptions are filled at the lesser of a 30-day supply or 100 unit dose. Two copays required for 90-day supply of maintenance drugs through mail order. 20% copay for injectables. For drugs on our approved list, excluded drugs and injectables subject to the 20% copay contact Customer Service. Not subject to out of pocket maximum.
12. INPATIENT HOSPITAL	\$250 copay per day; up to maximum of \$1,000 copay per admission
13. OUTPATIENT / AMBULATORY SURGERY	\$200 copay per procedure.
14. LABORATORY & X-RAY	\$30 copay \$150 copay per procedure for MRI/MRA/CT/PET scans.
15. EMERGENCY CARE <sup>3</sup>	\$100 copayment per visit (waived if admitted) Emergency Care covered in or out-of-network.
16. AMBULANCE	20% copay per trip. Not waived if admitted, not included in out-of-pocket maximum.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$50 per urgent care visit copay (\$100 if in emergency room) Urgent care may be received from your PCP or from an urgent care center. Care covered in or out-of-network.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE <sup>4</sup>	Coverage is no less extensive than the coverage provided for any other physical illness.

**STATE OF COLORADO**  
**2005 Colorado Health Plan Description Form -- Health Maintenance Organizations (HMOs)**

19. OTHER MENTAL HEALTH CARE a. Inpatient care b. Outpatient care	a. 50% copay (limited to 45 days) b. \$30 copay per visit (limited to 20 visits)
20. ALCOHOL & SUBSTANCE ABUSE	Inpatient: 50% copay (covered only for short term detoxification, rehabilitation not covered) Limited to one treatment per contract year, two treatments for lifetime. Outpatient: \$30 copay per visit (limited to 20 visits)
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Inpatient b) Outpatient	a) \$250 copay per day up to maximum of \$1,000 copay per admission. (Limited to 30 days per injury or illness) b) \$30 per visit copay (limited to 30 treatments per injury or illness)
22. DURABLE MEDICAL EQUIPMENT	50% copay (benefit limited to \$3,000 benefit payment per calendar year, combined with oxygen benefit (line 23), except for prosthetic arms and legs that are not subject to the maximum benefit payment, but does reduce the maximum benefit payment of \$3,000.
23. OXYGEN	50% copay (limited to \$3,000 benefit payment per calendar year, combined with durable medical equipment benefit (line 22)
24. ORGAN TRANSPLANTS <sup>5</sup>	\$250 copay per day, up to maximum of \$1,000 copay per admission. Cornea, heart, heart-lung, lung, kidney, kidney-pancreas, liver, bone marrow (only for certain medical conditions), peripheral blood stem cell. \$250,000 Lifetime Maximum Benefit.
25. HOME HEALTH CARE	No copay (100% covered) when authorized. Limited to 30 visits per calendar year.
26. HOSPICE CARE	No copay (100% covered) when authorized.
27. SKILLED NURSING FACILITY CARE	No copay (100% covered) when authorized; limited to 30 days per calendar year.
28. DENTAL CARE	No dental benefits are available under this medical plan. However, the State of Colorado offers two separate dental plans for eligible employees and dependents. See other enrollment materials.
29. VISION CARE	\$20 per visit copay limited to one visit every 24 months. Hardware not covered.
30. CHIROPRACTIC CARE	Not covered.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	Free child car seat program for expectant mothers who meet eligibility criteria; Smoking cessation program - \$150 lifetime benefit; Infertility Services: for diagnosis only - 50% copay. Hearing Aids – Covered up to \$500 once every three (3) years.
<b>PART C: LIMITATIONS &amp; EXCLUSIONS</b>	
32. PERIOD DURING WHICH PREEXISTING CONDITIONS ARE NOT COVERED. <sup>6</sup>	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THIS POLICY DEFINE A "PRE-EXISTING CONDITION?"	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier. Review them to see if a service or treatment you may need is excluded from the policy.
<b>PART D: USING THE PLAN</b>	
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	Yes
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes

**STATE OF COLORADO**  
**2005 Colorado Health Plan Description Form -- Health Maintenance Organizations (HMOs)**

38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
39. What is the main customer service number?	1-800-475-8466 or 1-719-589-3696
40. Whom do I write/call if I have a complaint or want to file a grievance? <sup>7</sup>	Complaint & Grievance Coordinator San Luis Valley HMO, Inc. 700 Main Street, Suite 100 Alamosa, CO 81101 1-800-475-8466 or 1-719-589-3696
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy Form SLV/SOC2005 Large Group Only

**PART E: COST AND MEDICAL EXPENDITURES**

43. What is the cost for this plan?	Employee Portion	State Contribution	Full Premium
Employee only	<b>\$ 87.10</b>	<b>\$178.06</b>	<b>\$265.16</b>
Employee + 1 dep.	<b>\$223.48</b>	<b>\$303.50</b>	<b>\$526.98</b>
Employee + 2 or more dep.	<b>\$316.74</b>	<b>\$420.02</b>	<b>\$736.76</b>

**PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT**

<p><b>Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan may request answers to the questions listed below. The request may be made orally or in writing to the plan administrator and shall be answered within five (5) working days of the receipt of the request.</b></p> <ul style="list-style-type: none"> <li>• What are the three most frequently used methods of payment for primary care physicians?</li> <li>• What are the three most frequently used methods of payment for physician specialists?</li> <li>• What other financial incentives determine physician payment?</li> <li>• What percentage of total Colorado premiums are spent on health care expenses as distinct from administration and profit?</li> </ul>	<p>Operations Manager San Luis Valley HMO, Inc. 700 Main, Suite 100 Alamosa, CO 81101 1-800-475-8466 or 1-719-589-3696</p>
--	--

**STATE OF COLORADO**  
**2005 Colorado Health Plan Description Form -- Health Maintenance Organizations (HMOs)**

<b>ENDNOTES</b>			
1. " <u>Network</u> " refers to a specified group of physicians, hospital, medical clinics and other health care providers that your plan may require you to use in order to get any coverage at all under the plan, or that the plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) that if you don't (i.e., go out-of-network).	2. " <u>Out-of-pocket maximum</u> ." The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.	3. " <u>Emergency care</u> " means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.	4. " <u>Biologically based mental illnesses</u> " means schizophrenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
5. " <u>Transplants</u> " will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.	6. " <u>Waiver of pre-existing condition exclusions</u> ." State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.	7. " <u>Grievances</u> ." Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of these procedures.	

**STATE OF COLORADO**  
**2005 Colorado Health Plan Description Form -- Health Maintenance Organizations (HMOs)**

Item #	Subject	Page
	<b>PART A: TYPE OF COVERAGE</b>	<b>1</b>
1	Type of Plan	1
2	Out-of-network covered	1
3	Areas of Colorado where plan is available	1
	<b>PART B: SUMMARY OF BENEFITS</b>	<b>1</b>
4	Annual deductible	1
5	Out-of-pocket annual maximum	1
6	Lifetime or benefit maximum paid by the plan for all care	1
7A	Covered providers	1
7B	With respect to network plans, are all of the providers listed in 7A accessible to me through my primary care physician?	1
8	Routine medical office visits	1
9	Preventive care	1
10	Maternity	1
11	Prescription drugs	1
12	Inpatient hospital	1
13	Outpatient/ambulatory surgery	1
14	Laboratory & x-ray	1
15	Emergency care	1
16	Ambulance	1
17	Urgent non-routine after hours care	1
18	Biologically-based mental illness care	1
19	Other mental health care	2
20	Alcohol & substance abuse	2
21	Physical, occupational, & speech therapy	2
22	Durable medical equipment	2
23	Oxygen	2
24	Organ transplants	2
25	Home health care	2
26	Hospice care	2
27	Skilled nursing facility care	2
28	Dental care	2
29	Vision care	2
30	Chiropractic care	2
31	Significant additional covered services	2
	<b>PART C: LIMITATIONS &amp; EXCLUSIONS</b>	<b>2</b>
32	Period during which preexisting conditions are not covered	2
33	Exclusionary riders	2
34	How does this policy define a "preexisting condition?"	2
35	What treatments and conditions are excluded under this policy?	2
	<b>PART D: USING THE PLAN</b>	<b>2</b>
36	Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	2
37	Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	2
38	If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	3
39	What is the main customer service number?	3
40	Whom do I write/call if I have a complaint or want to file a grievance?	3
41	Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	3
42	To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	3
	<b>PART E: COST AND MEDICAL EXPENDITURES</b>	<b>3</b>
43	What is the cost for this plan?	3
	<b>PART F: PHYSICIAN PAYMENT METHODS, &amp; PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION &amp; PROFIT</b>	<b>3</b>
	<b>ENDNOTES</b>	<b>4</b>